

CVS/pharmacy AUTHORIZATION FORM

One CVS Drive, Woonsocket, RI 02895

Fax (401) 652-1593

PATIENT REQUESTING DISCLOSURE

Name: _____
Address: _____
Address: _____
Date of Birth _____

I hereby authorize CVS/pharmacy to disclose my Patient Prescription Record (PPR), reflecting information regarding my pharmacy services as set forth below:

1. My Patient Prescription Record (PPR), may be disclosed to the following person(s):
Name: _____
Address: _____
Address: _____
2. I understand that I may revoke this authorization at any time by writing to CVS/pharmacy Privacy Office, 1 CVS Drive, Woonsocket, RI 02895, or fax to 1-401-652-1593, except to the extent that CVS/pharmacy has taken action in reliance on this authorization.
3. I understand that I am signing this Authorization of my own free will and that this authorization will not affect my ability to obtain treatment from the Pharmacy. I hereby state that this disclosure is at my request. A photocopy or facsimile of this signed authorization is as valid as the original and will be accepted.
4. I understand that if the person or entity that receives my PPR is not required to comply with the federal privacy regulations, the information described above may be redisclosed and would no longer be protected by those regulations.
5. This Authorization will expire 6 months from the dated signature on this authorization unless otherwise indicated here _____

Signature of Patient or Personal Representative *_____
Date

*To the patient's personal representative, explain your authority to act on behalf of the patient: _____

